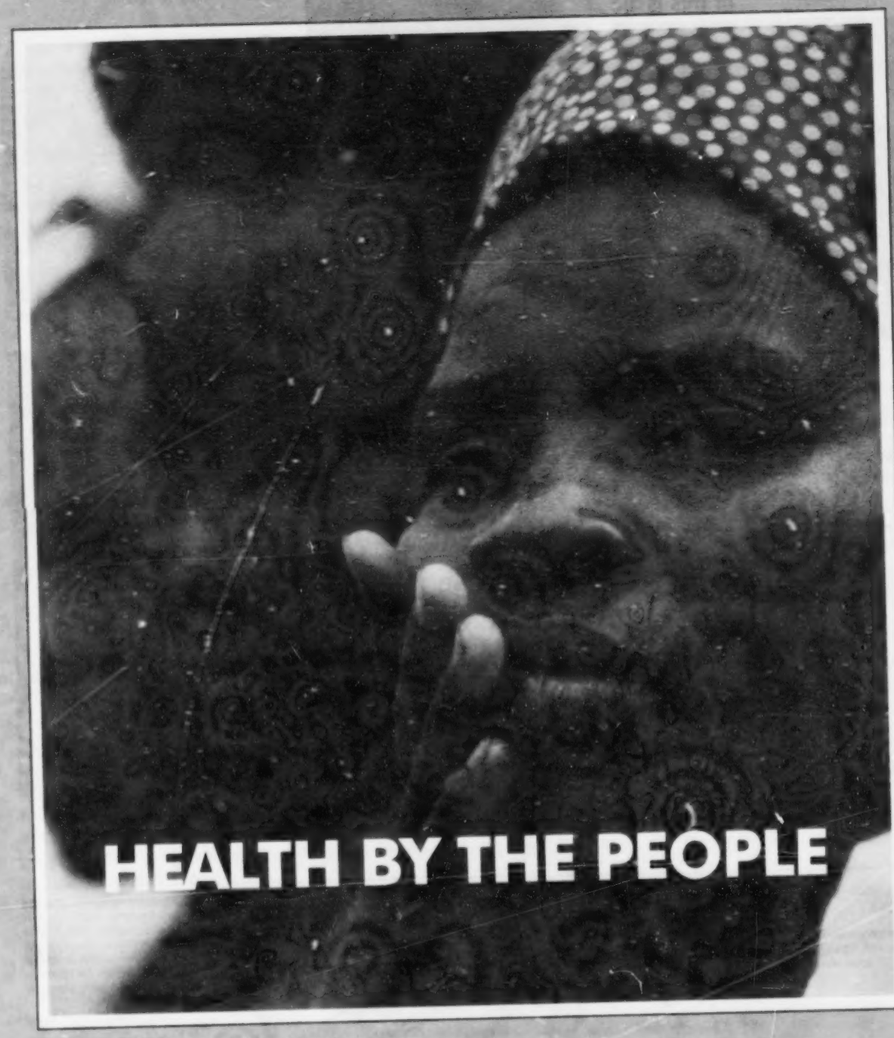
WORLD HEALTH

THE MAGAZINE OF THE WORLD HEALTH ORGANIZATION

MAY-JUNE 1992



HEALTH BY THE PEOPLE

WORLD HEALTH
THE MAGAZINE OF THE WORLD HEALTH ORGANIZATION

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World Health ■ May–June 1992
IX ISSN 0043-8502

Correspondence should be addressed to the Editor, World Health Magazine, World Health Organization, CH-1211 Geneva 27, Switzerland, or directly to authors, whose addresses are given at the end of each article. For subscriptions see order form on page 31.

World Health is the official illustrated magazine of the World Health Organization. It appears six times a year in English, French, Portuguese, Russian and Spanish, and four times a year in Arabic and Farsi. The Arabic edition is available from WHO's Regional Office for the Eastern Mediterranean, P.O. Box 1517, Alexandria 21511, Egypt. The Farsi edition is obtainable from the Public Health Committee, Iran University Press, 85 Park Avenue, Tehran 15875-4748, Iran. The Russian edition can be obtained from "Meditsina" Publishing House, Petrovenglski per., 6/8, 101000 Moscow, Russian Federation.

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Editorial

A grand alliance

People are the true measure of the success of policies and programmes. At the same time, people are the determinants of success. Experience teaches us that, whether in the most sophisticated cities or in the most remote villages, when people act with determination and understanding in pursuit of goals they deem essential, they achieve success. Previously insoluble problems are solved and resources are mobilized. Miracles happen!

So it is appropriate that community participation forms the theme of this issue of *World Health*. But we must deal honestly with the concept of participation or involvement. It means much more than merely complying with medical prescriptions or contributing labour or money to health plans that others have already judged appropriate for the people. Expressed simply, community participation is a grand alliance between people, policy-makers and health workers for a common purpose.

A lay health resource

It is imperative that this alliance should be democratic and not manipulative. If they are given the right and responsibility to participate and are appropriately supported, people have the wisdom, the ability and the will to deal with their own development. The challenge to policy-makers and health workers is to get the best out of the "lay health resource" that people represent. Ordinary men and women are the most abundant, most effective and most economical tool for meeting health needs. For example, it has been estimated that well over half of all health care is self-care or care provided by the family.

We must learn to harness the energy, wisdom and will of the people we serve.

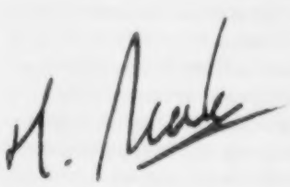
Achieving community participation is neither cheap nor easy. It requires a long-term investment in training and reorientation. Sometimes social and cultural values or beliefs interfere. Sometimes bureaucracy and excessive centralization make it hard for the community to see what is expected of it.

But these difficulties are surmountable, and the results are worth the effort and the time. Let me give a dramatic example. In one country embroiled in civil war, facing social collapse, the only hospitals and health centres not looted or burned were in a district where, with WHO's cooperation, there was strong community involvement in health. By their action, the people were saying that they would not loot and burn *their* own hospitals and clinics.

The second evaluation of implementation of the Global Strategy for Health for All by the Year 2000 shows that a large majority of Member States consider community involvement to be not only a political necessity but also an important and effective mechanism for planning, carrying out and evaluating health programmes. Many countries have participation mechanisms that are in full working order or are being further developed. Clear national policies and strategies; individual and collective leadership; sustainable mechanisms, especially at the community level; and appropriate investment in time and money — these are some of the key factors for success.

Dr Hiroshi Nakajima, Director-General of the World Health Organization

The great challenge we face is to establish and sustain systematic and routine practical measures which will bring about a democratic alliance between people and their health services. The growing worldwide trend towards greater democracy and democratic values seems likely to bring this goal nearer. ■



Hiroshi Nakajima, M.D., Ph.D.

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WHO Interview

Wisdom and guidance from the community

Dr Haile Mariam Kahssay is responsible for community participation in the Division of Strengthening of Health Services, WHO, Geneva. He was interviewed by World Health.

Dr Kahssay, at the Alma-Ata Conference on Primary Health Care in 1978, it was stated that community participation is needed to implement primary health care, and that it was understood in different ways in different countries. What do you mean by community participation?

At Alma-Ata the principles of community participation were clearly defined. To me, it simply means that you cannot have health without the involvement of enlightened people who have been informed and educated about their health situation and about what can be done to improve it. Communities may be large or small, and may function differently, but the principles of participation remain the same.

Has community participation now become part and parcel of health programmes around the world?

Unfortunately not. There has been a lot of discussion and much rhetoric. But only a few countries have systematically included community participation as part of their health development plans. Even fewer have started teaching doctors, nurses and other health workers how to work *with* people, rather than *for* people.

But people are, and always have been, interested in their health. A great deal of health work is done by individuals and private organizations, and health workers themselves are showing much more interest in what they are doing. But few health systems have really tried to support community health initiatives in a systematic way.

What should be done to enable communities to become partners and a vital force in health development?

WHO recently arranged a study group on community participation; the group's report had the subtitle "Challenging the health services". Clearly the health workers and the health systems must learn to accept people's involvement including their participation in decision-making. Ministries of Health need to establish clear guidelines, which will address control of resources, decision-making and administrative rearrangements. We need laws and regulations that will enable people to participate. We need decentralization, enabling health workers at the local level to take decisions. And as I said before, health workers must learn to work *with* people, accepting them as partners and not just receivers of care.

Sometimes it has been said: "Well, we delegated to the community and everything went wrong because people took the wrong decisions". Communities may lack the technical know-how and might get their priorities wrong. How can we ensure a balance between technical

Well-informed people know how to protect their health and improve it.

requirements and the communities' wishes? How do we reconcile village priorities with national priorities? These are the challenges, not shortcomings, of participation.

Some people talk about the negative aspects of community participation, but that is like talking of the negative aspects of democracy. I don't think there are any inherent negative aspects. Of course things can go wrong. And nobody says: "just leave it all to the people". That would be nonsense, because the community does not necessarily have the technical knowledge to make informed decisions. What we need is joint action between the community and the health system.

It is easy to say: "leave it to the community". Is community participation sometimes used as an excuse to keep things as they are?

Yes, that happens a lot. Health planners especially like to say, "We have community participation", and all they mean is "We are leaving the rural areas and the slums to themselves". That is a subversive interpretation, which simply means abandoning populations. The major misunderstanding — or deliberate misinterpretation — of the primary health care approach has been for planners to assume that community participation will finance rural health. This left parts of populations to their own means, which enabled the planners to concentrate on hospitals, postgraduate training, and centrally directed programmes. Fortunately, there is a better understanding today.

Sometimes it is said that it is easiest to work in rural communities where there are traditional social structures. In urban slums it is said to be more difficult because families and communities are fragmented.

Yes, that was a first impression. But many studies, especially in WHO's Region of the Americas, have shown that it is sometimes easier to organize community participation in urban slums.

Why is that?

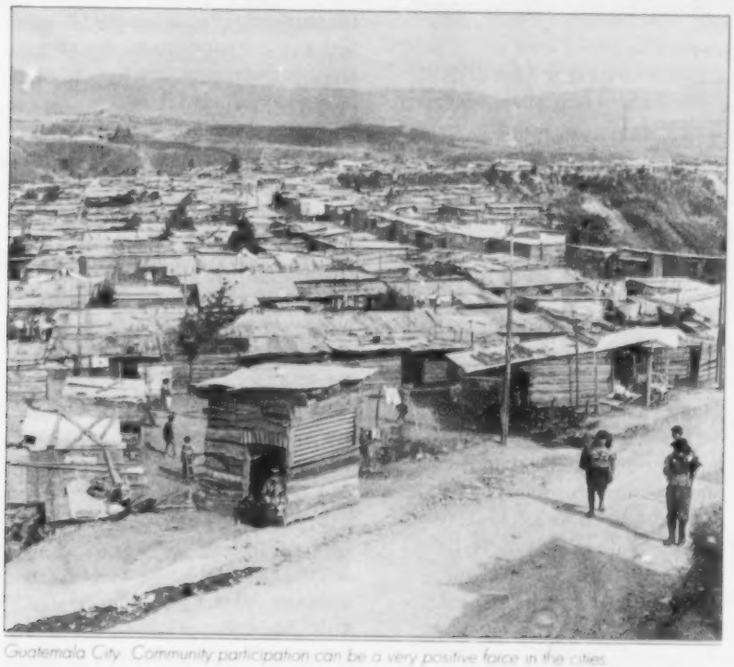
Because the neighbourhoods are nearer to each other, and are more easily approached. The real problem begins when the population is constantly moving. But in many squatter areas, people are well organized after having lived there for many years. There the problem often arises that, because they are on land that they do not own, municipalities do not recognize them and refuse to work with them.

How could the readers of *World Health* get involved in health activities? How could they start?

Starting should be the least of our problems. A large number of community groups already do exist. Some of them are involved in health activities, others not. Motivated readers could join them, because people everywhere are interested in health. It is the health systems which are resistant, because health workers have been trained to work for people rather than with them.

Maybe we could conclude by saying that communities are concerned about their own health, and that there is already much collaboration with the health services. But governments should increase the possibilities for local communities to influence and participate in action for health. Health workers should be trained to understand their community and be taught how to work with people.

Yes, it is essential that everyone clearly understands that communities should not only provide money, land and labour, but should contribute to health both intellectually and in decision-making. This is essential especially with regard to rural and poor urban communities. You see, I believe that health and other development workers either do not know how rural and poor urban communities work and live or they have been "educated out" of and become blind to these situations. Therefore they need wisdom and guidance from the communities in order to do meaningful work. ■



Guatemala City. Community participation can be a very positive force in the cities.

Among the street children

Ana Filgueiras

When all doors are locked ...

It is easy to understand that these children have a wide range of immediate needs, and that health is not a priority for them — much less AIDS prevention.

S.O.S. Child and Adolescent is a humanitarian organization working directly with young people who live or work on the streets of Brazil's big cities. Most of these children are victims of various forms of violence ranging from abandonment and physical abuse to torture and even murder.

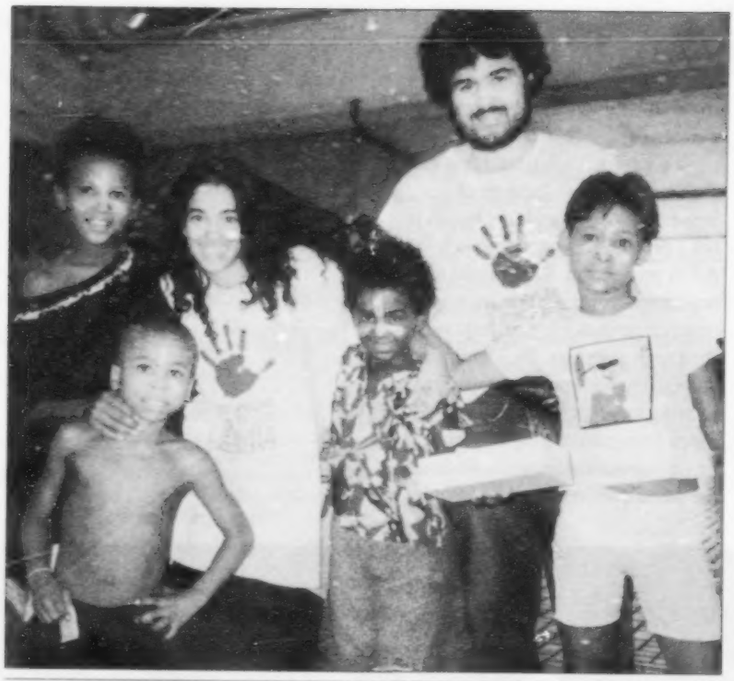
A matter of survival

Miserable living conditions and domestic violence are two of the major reasons why these young people either leave home or are sent out to the streets in order to make money to support their family. Very often, women abandoned by the father of their children are left to support the household alone. As a result, family ties are broken and these children move away from their communities and form alliances with other street children in order to survive.

The daily lives of these young people are made even more difficult by the inefficiency or lack of public services that are intended by law to satisfy their basic social rights. The only public authority that seems able to reach them is the police. However, instead of protection, physical abuse and murder are common methods used by the security forces when dealing with young people living on the streets.

Harried by the constant violence and social segregation, these children seek alternative ways to generate income. Girls on the streets, lacking the same opportunities as boys and with frequent experiences of sexual abuse in most cases, turn to prostitution as a last resort.

Sniffing glue, smoking marijuana, mixing and injecting all kinds of drugs they can get hold of (or that they are involved in selling for others), are the only real supports they have to compensate for solitude, fear, hunger and pain. As Simone, a 12-year-old girl, says: "When I sniff glue I go everywhere. I don't need to eat and I can do all the crazy things." These children also count on divinities or spirits to protect them from various diseases including AIDS. Ricardo, an 11-year-old boy, exclaims: "AIDS? God will protect me!" Given their experience of violence and death threats, they find it irrelevant to associate AIDS with death. "AIDS kills? The police or anyone else can kill us too!" is their common response.



Educators and street children join forces for a better future

Sharing the good and the bad

Our group meets these children and adolescents in their own community: the street. Every day, a team of educators joins them in a particular spot where they usually gather. Informal conversations start, raising all kinds of concerns, sharing the good and bad news. Together everyone tries to come up with solutions. Health is a very wide component of the needs defined by the children themselves. Priorities range from the need to find a place to eat or how to face the danger of a known aggressor, to how to deal with fever, pain or an infected wound.

Aware that children are as biased as any other Brazilian adult, we try to identify, behind the concepts they use, what kind of sexual activities they are involved in, focusing much more on how they do it rather than why they do it. Youths living on the streets frequently separate their sexual activity from what they assume is their sexual identity. Thus these young people only identify a boy as a homosexual if he plays the passive partner role on a systematic and voluntary basis.

For girls, more often faced with the real threat of physical abuse or rape either within the family or from the boys they meet on the streets, establishing a relation with another girl may not necessarily mean a definition of their sexual orientation. As Rosemary, aged 15, explains, "I can have sex with my girlfriend without being a lesbian, but if I get jealous about her then I am a *sapatão*" (common word for lesbian). Knowing the difficulty of changing the sexual behaviour of any teenager and particularly of this group, we have tried to avoid making constant critical comments or moral judgements on their behaviour. Our main goal is to convey information that may contribute to saving their lives by "doing it" in a safer way.

Defenders of these children

We believe that the essential role of groups like ours is not to provide treatment, care, formal education, housing or any of the basic social rights which are the responsibility of the State under the Brazilian Constitution. Even if we could afford to offer such services, we would only be able to reach a minority within a marginalized juvenile population that is estimated in millions. Therefore we act as "defenders" of this specific group's social rights, pressing the public services to fulfil their responsibilities towards young people at social risk, and avoiding creating parallel services for them which we feel can only serve to underline their discrimination. So we are slowly beginning to "open doors" within the existing public health services.

Our first appointment is with the director of a specific clinic, followed by personal contacts with nurses, doctors or other health professionals who may show more sensitivity in dealing with these youths. Short meetings are planned where educators involved on the outreach programme describe their work on the streets. Curiosity first and then favourable attitudes from some professionals help the youth to make their first attendance. Joint work begins through written but confidential individual reports which help us to establish individual follow-ups of each young person in need. The good impressions from our first patients are disseminated among their peers, and gradually others take the initiative to go on their own to this health service they have heard of.

Familiarization with condoms helps to prevent AIDS

In order to bring about a change in the behaviour of young people who live on the streets, we need to integrate with the people who belong to their "street community", who are part of their daily contacts. This is the community who can help us to obtain a supportive environment. Sex workers (female, male or transvestite), journalists, police, small shopkeepers, street vendors and so on are very important.

While some educators are working directly with the children, parallel contacts are established with other people who frequent the area. Volunteers help with the distribution of free condoms and leaflets on how to prevent sexually transmitted diseases and referrals to health clinics. Thus we bring together the adult community and these children's universe.

It is easy to understand that these children have a wide range of immediate needs, and that health is not a priority for them — much less AIDS prevention. So we need to root our actions for health promotion in concrete attitudes which respond to their own priorities. By identifying and raising common concerns, we try to bring together the different actors either from community organizations or governmental agencies, widening the participation of society in order to make an impact on the public health services. Only then will we be able to contribute to the control of HIV infection among young people at social risk. ■

Ms Ana Filgueiras is President of S.O.S. Child and Adolescent, Rua Barao de Jaguaribe 316/201, Ipanema, CP 22421, Brazil

A young girl helps to promote and distribute condoms

Games for learning about AIDS

Does the community participate?

How can we find out to what extent there is community participation in health action, and how can it be stimulated and improved? A group could be created to evaluate the situation. It could consist of some health workers, representatives from local voluntary organizations, women's groups and youth groups, and maybe a teacher or other specially interested individuals. The purpose of the evaluation is not to report to some higher authority, but to provide information to the local community so that community participation could be improved. This is why it is important for the local people themselves to be responsible. The evaluating group should look into the following aspects of participation.

- What are the relations between the community and the health workers? Do they meet regularly? Do they collaborate on specific projects?
- Do the health workers agree to let the community decide on local matters such as the working hours of the health post?
- Is there a health council or other group that meets regularly, and which has well-defined responsibilities?
- Are people willing to participate? If not, why not? Are there different interest groups in the village which do not want to work together? Is there no perceptible interest for health matters in the village? Why?
- In what activities does the community participate — in planning and evaluation, in decision-making, in providing funds or voluntary labour, in contacting higher political and administrative authorities to obtain support?
- What have been the results of community participation? Have people become more aware of the importance of health? Are they more satisfied with the health care provided? Has it improved? Is health improving?

The findings should be written down and discussed. Hopefully, they will result in better collaboration between the health workers and the community. Things can always be improved!

Trust in the people

"Poor health in young people does not derive from illness but from lack of hope, which results in a turning inward and isolation."

The mission hospital in Tokombere, a rural and mountainous area in northern Cameroon, had a qualified and dedicated staff. But in spite of an ever-increasing number of patients seen, greater use of medicines, progress in the quality of health care and higher health expenditure, the health status of the population had not been improving.

In 1976 Dr Christian Aurenche started to work in Tokombere. He launched a new approach. Instead of the traditional situation where the hospital is the centre of the health care system, he made the village the centre and the villager the first health actor, while the health professionals offered technical support for the villagers. To achieve this, the attitudes and ways of work of the health workers had to change. Instead of spending their time in only looking after the sick, the health workers became actively involved with the community in studying and solving its own health problems. Village health committees took shape. Mobile health staff provided practical information on health and what could be done to improve it.

The training of health workers had to change. Instead of receiving lectures on how to work with communities, they had to go to the villages and learn. They also had to learn to accept that initiatives taken by the community had to be taken seriously and supported. But trusting the people implies that government officials and administrative councils, as well as health workers, should never undertake a project without having first consulted the people, nor should they change it without having at least informed the community. "What humility that requires!" exclaims Dr Aurenche. "I have never before seen it in the field, and that explains why it is so difficult to make a local primary health programme last."

Eager to learn

According to Dr Aurenche, educating people does not present any problems: they are so eager to learn and so greatly desire to have better health. He never ceases to be amazed by the creative dynamism of a population stimulated in turn by a dynamic health committee. He comments, "Here I must mention a group of women responsible for nutrition in one village, who came with a request for help in opening a 'good nutrition' restaurant in the market at Tokombere, both as a source of funding, and because they wanted those who came to the market to learn how to feed themselves better".

He also recalls the opening of a peasants' centre, which is now the heart of a self-run rural development project. There, young people who have finished school receive further training. The programme includes self-run boarding schools, and a youth club in Tokombere with video, a library and a lecture hall. This is important, says Dr Aurenche, because "poor health in young people does not derive from illness but from lack of hope, which results in a turning inward and isolation".

Activists for health

To create a real partnership between the population and the health workers, even the ways in which future health workers were selected had to be changed: candidates had to agree to work in the villages. But the real difficulty lay in the lack of reform of their basic training. Another problem was that political leaders have hesitated to agree to the training of activists who can take responsibility for health in their own community.

Much has been done to improve health in Tokombere. And yet, says Dr Aurenche, it still needs to be demonstrated that "health is not simply the end result of technique, and that human beings do not require merely to be repaired or even protected. People want to *be* — that is, they want to be free, responsible, creative and in control of their environment". ■

Dr Christian Aurenche is a French physician who was awarded the Sasakawa Health Prize by WHO in 1988 for his dedicated efforts in supporting the health development of the people in Tokombere. His address is Centre de Promotion de la Santé de Tokombere, B.P. 74, Maroua, Cameroon.

Villagers learning to become health activists

Listen to the community!

Lowell S. Levin

As professional health educators, we were not completely prepared for an actual loss of control. The first shock came when the community rejected our priority list of health subjects.

Knowing the community's own health priorities is vital for good health planning

There is no mystery about community participation in health. The health care of ordinary people, for example, is mostly provided by self-care, or through family and friends, or through religious and voluntary groups. Only a small proportion of health care (perhaps as little as 10 – 15%) is provided by health professionals. Communities therefore have considerable responsibility for promoting good health through their investments in education, economic growth, social resources like recreation, and environmental protection. No professional service system could effectively or economically replace this "natural" social resource for health.

Professional planning and services should now be brought into clearer alignment with the community's priorities and preferences. This is not easily accomplished. It involves many stresses and strains on health professionals who, in the past, have not taken into account the community's resources, priorities and views on how to proceed. Here I speak from personal experience.

Some years ago I agreed to assist an inner-city community of the "working poor". Most individuals suffered from the well-known health problems associated with poverty, including heavy dependence on local hospitals for primary, non-emergency, medical care. They requested help in learning basic self-care skills as well as skills in achieving a more effective and informed relationship with medical care providers. From the start, my colleagues and I agreed on a model of empowerment: to put the entire educational process into the community's hands. Our clients told us what they wanted to learn, how they preferred to be taught, and what criteria should be used to evaluate the results. The power relationship between educators and clients was completely reversed, or at least equalized.

The right priorities

Even though we intended that this should happen, we professional health educators were not prepared for an actual loss of control. The first shock came when the clients rejected our priority list of health subjects. Their priority was *not* nutrition knowledge or child care, but learning how to run a campaign to get more of their

neighbours to vote in the city elections! According to them, that was the most urgent health issue. With electoral control, they reasoned, the community could get its health needs met through better schools, an accelerated housing programme, and reduced air pollution.

They insisted on educational methods where we professionals could learn as well as teach. One subject they wanted to teach us was "the community's medicine" — effective remedies that were part of the indigenous culture. Mutual learning replaced the traditional teacher/learner relationship. When the time came to evaluate the programme, they opened our eyes to criteria that really were important to them. Thus, the accumulated effect of what they learned was the crucial factor, not the attainment of specific knowledge or skills. By this they meant their sense of enhanced self-worth and the community's recognition of their special competence as a health resource.

Learning through dialogue

This experience with community participation taught us things that only experience can teach. At the top of the list is humility, coupled with profound respect for the collective wisdom of the community. We learned about the "blinder effect" of professional education, an effect that blocked our view of the knowledge and preferences of people we purport to serve. We learned that sharing the process with community members also means sharing responsibility for outcomes. We were in it together.

It is easy to understand why there are still relatively few examples of vigorous and full community participation in health services and health planning. Effective community participation is not simple or spontaneous. Often little things can derail the process — for example, locating a mutually comfortable, neutral venue for dialogue between professionals and the community. The hospital conference room is the intimidating reserve of health professionals. Try the community's home ground — a library, school, hall, or village meeting place are less likely to inhibit the free exchange of ideas. A special effort is required to overcome years of indoctrinated silence in the presence of powerful professionals, especially physicians.

Community participation may change present strategies and procedures. Unlike health planners, for example, and their assessment of needs, communities may wish to start with an assessment of preferences — judgements about what to do, based on social rather than epidemiological determinants. Health planners normally focus on preventing specific diseases; the community, in contrast, may place a higher priority on structural changes (like improving education and employment), where the health impacts are not disease-specific but promote health generally. These are not necessarily incompatible goals and approaches, but they require different strategies, participants, costs and outcome measures. Community participation will force some hard choices that must be made clear and agreed to at the outset.

When the community is fully involved in all aspects of health development, new ideas and practices are widely and rapidly diffused. Social networks are activated. People with similar values and experience trust and accept advice from each other more readily than they do from "authority figures", whose motives and social credentials may differ from those of the population they serve. Perhaps in the final analysis, reaching the hard-to-reach on their own terms may be the most valuable contribution of community participation.

Modern public health practice is increasingly appreciating the practical as well as the ethical benefits of community partnerships. The challenge now is to try innovative ways of strengthening these partnerships. Listen to the community: they can help us to help them. ■

Where there is little dialogue between professionals and patients, community participation is unlikely to succeed.

Dr Lowell S. Levin is Professor of Public Health in the Department of Epidemiology and Public Health at the Yale University School of Medicine, 60 College Street, Box 3333, New Haven, CT 06510, USA.

WHO Interview

Safe motherhood in Tanzania

She is the lawyer, the doctor, the cook — she is everything!

"Previously, it would have been unimaginable for a leader from a women's organization to participate alongside medical doctors! Today issues of health are not only issues for the doctors, but issues for everybody."

No one knows exactly how many women die in pregnancy and childbirth. WHO estimates their number at 500 000 each year, 99% of them in the developing countries. It is in Africa that the risks are highest.

The Safe Motherhood Initiative aims to reduce globally maternal deaths by at least half by the year 2000. What effect will such an effort have on the lives of women in Africa? Kate Kamba, Secretary-General of the Union of Women of Tanzania, explained it to ***World Health*** during a WHO meeting on safe motherhood.

Safe motherhood covers all aspects which contribute to make women safe during the hazards of pregnancy and delivery. Some groups are more at risk than others, specifically girls under the age of 15 or women in their mid or late forties. Another aspect is the complications that arise during pregnancy and delivery because of the lack of awareness on the part of the mothers on how to manage themselves during pregnancy. For example, almost 60% of maternal deaths are caused by anaemia.

During pregnancy, you have to feed both yourself and the fetus. Whatever you eat, the fetus is not going to be sympathetic to you: unless you supplement your diet, the baby will take everything and you will be left with nothing! It is very important that during pregnancy you have enough fruit and vegetables, and when necessary — through a doctor or pharmacist — some iron tablets as well to supplement what you are eating.

Anaemia occurs because women are not actually aware that they need to eat a special diet. Sometimes they cannot afford to buy fruit and vegetables for the whole family; and, because traditionally in Africa women are the last ones to eat, they would consider themselves greedy if they were the only ones eating fruit and vegetables. This is a big handicap.

Also, because of economic hardships, women traditionally undertake many laborious activities and do not take rest. This uses up a lot of their energy, because they work right up to the time of delivery, instead of having some hours — or at least minutes — of rest each day, especially during the last months of pregnancy.

Education breeds awareness

Of course, there are some parts of Tanzania that are better off, and this depends on the level of education. In some areas, like the Kilimanjaro region, the local people have increased their education standard up to secondary level. So in these areas you find women who are quite enlightened on how to take care of themselves. Of course they have some cultural inhibitions, but if you compare this region to some of the very remote areas, you will find that people there are not even aware of the risks. Although they produce a lot of food crops, they have the highest malnutrition. They don't even eat vegetables — only pulses and maize meal — as there are no fruit or vegetables except during the wet season.

The Union of Women of Tanzania has branches at village level, with representatives at the district, regional and national levels. We hold meetings and workshops where we bring pregnant women together for training so that they can train others. We also provide them with some reading material to take away and keep for further use. We invite people from the Ministry of Health to attend our meetings and provide education. Family planning and health issues are on the agenda of all our meetings.

Opportunity for immunization

What we normally try to tell the women is that, when they are pregnant, they should attend a maternal health clinic. Secondly, they must be immunized because they don't know when they are going to deliver — whether at home or in hospital. Thirdly, we insist that they should rest. This needs a lot of community participation because, in most cases, the husbands don't understand; they think that the women have to go on doing things. We keep on telling such women that to rest is their right.

It is also important that they shouldn't have too many children. So we insist on family planning. We also train them to grow fruit and vegetables in the backyard gardens.

I really believe that this initiative is going to have a very big impact. Previously, it would have been unimaginable for a leader from a women's organization to participate alongside medical doctors! But there is a need for intersectoral coordination. This means that issues of health are not only issues for the doctors but issues for everybody.

Educate a mother and you educate a family

When you talk of the community, you talk of the woman and the father. But to make the Safe Motherhood Initiative successful, when you go into the household at the community level — the family level — it is the mother who is the key person because she is the manager of the home. She is the lawyer, the doctor, the cook — she's everything! So, if you educate the mother, you educate the whole family.

In our country, we have the human resources but we don't have the money. However, we can use the brains of the women to prevent rather than cure, because if we talk in terms of curing, we can't manage.

The mother and the child form a generation, so if we know how to protect them, we will have a healthy nation. People who are healthy are people ready to face anything — they are resistant to most of the problems which nature has put in the way of good health. ■

Ms Kate Kamba was interviewed by Ruth Landy of the Division of Health Education at the World Health Organization in Geneva. Her address is: Ofifi Kuu Ndogo, S.L.P. 1473 Dar es Salaam, Tanzania.

Regular follow-up of each pregnancy helps to prevent dangerous complications.

Family welfare afloat

Koes W. Mihardja, Titi Said & Imam Soedjahri

To persuade the "sea people" of Indonesia to settle permanently, they were offered locally built house-boats.

Indonesia's Province of Riau consists of part of Sumatra and about 3140 small islands. Many of these small islands are uninhabited; some may have only five family groups. Generally speaking, the islanders do not have a permanent residence or place to live; instead they constantly move from one island to another. For them, the sea is their "gold mine"; it gives them food and enables them to live, and it is their only source of income.

In common with many other islanders, the people of the Riau islands are born professional sailors, capable of dealing with heavy seas and stormy winds. One particular group, the *suku laut* or "sea people", live as fishermen aboard their vessels, always on the move from one place to another. This is the way they live, start their families and raise their children. Since going to school would mean sailing across the sea to reach a more populated island with educational facilities, the children do not attend school. As they grow up, they in turn become professional sailors and fishermen, just like their fathers and forefathers. Some 3600 people still maintain this way of life.

The Indonesian government has now developed a resettlement programme to transfer the *suku laut* to a more populated island called Bulang Lintang, where ethnic groups from various parts of the country can have permanent homes, learn from each other's experiences, and give their children better educational opportunities. Health services are also available.

But the deep-rooted traditional way of life is hard to change: people do not readily abandon their habits, customs and beliefs. The *suku laut* prefer life on their boats — the feel of the wind and the smell of the sea.

A cool breeze from the sea

To persuade them to settle permanently, they were offered house-boats built by the shore of Bulang Lintang. There they can still feel the cool breeze from the sea, and the waves make their floating homes dance up and down.

One of the 15 "houses-on-vessels" opens regularly once a month for Posyandu activities; this is an abbreviation of Pos Pelayanan Terpadu, or integrated health post, a subsystem of the health services. It is initiated, organized and managed by the community, for the community and among the community, with technical support from the local Health Centre's staff.

The local PKK motivating team is responsible for mobilizing and generating resources that can contribute to bringing about the desired social changes. PKK is a well-known social development movement in Indonesia, standing for Pembinaan Kesejahteraan Keluarga (PKK), or Family Welfare Movement. The PKK motivating team operates at all civil administration levels — national, provincial, subdistrict and village. The vertical and horizontal communication system within the organization makes it much easier to generate social change and mobilize local resources for development purposes.

In order to acquaint the *suku laut*

The PKK motivating team sets out for a field visit

with the health services system, the motivating team encourages the women, especially those with babies and children under five, to visit the floating Posyandu. This is only a way to attract the people to participate in this endeavour. The PKK volunteers deal with the registration of babies and recording their weight, and offering information on health, nutrition and personal and environmental hygiene and sanitation. Medical services such as immunization and health examinations are carried out by the health centre's staff.

PKK local volunteers are usually women, who have been trained to carry out PKK programme activities.

An attractive scene

Little by little, the *suku laut* have seen the benefits of all this, and next time round they will cheerfully bring their babies and children under five to be weighed and immunized. Not the least of the attractions is the offer of nutritive food for the children.

The whole scene also attracts passers-by whose boats happen to be in the area, and they look in to see what is happening on Posyandu Day with its noisy crowds and the yells of babies and children.

Field visits from the PKK motivating teams representing upper levels help to encourage educational values and greater cooperation within the community. Besides drawing people's attention to health and health-related matters, Posyandu Day offers an opportunity to deliver messages relating to health, environment, food and agriculture. It also becomes a pleasant opportunity to sell individual products and raise the family income. Gradually the people are introduced to the way of life on land. The Family Welfare Movement also proposes leisure time activities and shows how simple manual skills can produce goods that can be sold in the market. When individuals show that they have talent, technical support is available to develop whatever professional skills may be needed. ■

Monitoring the health of all children under five.

Being skilled in embroidery can mean additional income and better welfare for the family.

Ms Koes W. Mihardja, Mrs Titi Said and Mrs Imam Soedjahri are Central PKK staff. Their address is Tim Panggerak PKK Pusat, c/o Komplek Ditjen, Pembangunan Desa, Jl. Raya Pasar Minggu, KM 19, Jakarta Selatan, Indonesia.

We dream of the Land
where children are running to
and fro.

We dream of Posyandu
where babies are being weighed
and health messages conveyed.

The Child is God's Gift
that we should raise
with Love and Faith
to educate the future generation
for the health and wealth of the
Nation.

Lyric by: Titi Said

Translated into English: Koes W. Mihardja

Health b

1. Discussing health

2. Building your health post

3. Making your needs known

Health gardens for the community require loving

Communities and individuals have always been concerned with their health and participated in health activities. During the 20th century such participation has become more effective through the creation of voluntary organizations at local, national and international levels. People are also much better informed about health matters. The policy, adopted at the conference on Primary Health Care in Alma-Ata in 1978, of involving communities in health development in a more organized way has accelerated this trend. Thus, in 1992 the World Health Organization could report that most countries consider community involvement in health not only a political necessity but also an important mechanism for planning, implementing and evaluating health programmes.

Health matters are frequently discussed in local communities (1). In many countries these communities are represented in health councils and hospital boards, and students participate in school health committees. Health is also a popular theme in newspapers, magazines, radio and television.

Health posts and health centres are often built by communities which provide voluntary labour (2) and materials. It is important that the construction plans should be coordinated with the government, since the community will expect the government to cover the staff salaries and the cost of drugs, equipment,

the people

transport and so on.

People influence health policies through consumer associations and other groups such as patient groups. Recently some of the most active pressure groups have been concerned with the deterioration of the environment (3).

Community health workers, who are selected and often paid by their local communities, provide the needed health care (4); in many parts of the world they are the only permanent health workers in villages. Many nongovernmental organizations also provide health care, as well as support to patients and their families, home care, and other services through volunteers.

Environmental sanitation has traditionally been a field where male volunteers have done much of the work; they install water pumps (5), construct small sewer systems, and maintain and repair them. Women have become increasingly involved in such activities as repairing and maintaining handpumps.

Most health care is provided by the family, particularly the mothers. Increasingly, fathers and other family members are becoming involved in such activities as rehabilitation of the handicapped (6). Family members can also give oral rehydration for diarrhoea, take care of the sick and the elderly, and provide many other services. ■

4. Health care for all

5. Installing your water pump.

6. Helping those who need it.

Democratic psychiatry

Margot Wicki-Schwarzschild

An association in Basle, Switzerland, founded to encourage psychiatric patients to assume responsibility for themselves, has become a model of self-help and voluntary cooperation.

The initial idea of "democratic psychiatry" arose from a protest against the way in which traditional psychiatry was normally being conducted in Basle, Switzerland, and elsewhere at the end of the 1970s. In 1979, a group of people came together who were interested in opening up and "democratizing" psychiatry, that is, making patients the focus of attention and enabling them to assume responsibility for themselves and join in discussions about treatment. This group of "reformers" consisted of patients, psychiatric nurses, students and physicians, as well as other people (primarily relatives) who had become interested.

A movement against traditional psychiatry was slowly gaining a foothold in Switzerland and abroad. Franco Basaglia in particular had thrown open the doors of psychiatric clinics in Italy, a move which resulted in a fiasco since the population "outside" was not yet ready to accept people with mental problems. Basaglia's ideas, however, set their stamp on the Basle group and were taken up in the group's action programme. Indeed it was he who gave the group its name of "Meeting-point for Democratic Psychiatry" (Treffpunkt Demokratische Psychiatrie), which is today a model of self-help and voluntary cooperation.

The main aims of the group are:

- to reserve inpatient stays for short-term interventions in acute crises;
- to encourage outpatient facilities *outside* hospitals for after-care (counselling, accommodation, work, leisure, meeting-points);
- to promote self-responsibility and the right to dialogue;
- to use the patient's own resources and promote self-help;
- to extend patients' rights;
- to break down hierarchical grading so that the patient is no longer the lowest link in the chain;
- to find pathways leading out of isolation and back into society;
- to involve relatives in work with patients.

A second home

After numerous meetings and discussions of principles, the members of the group (who had in the meantime dwindled to a "hard core") decided to stop talking and start acting. In September 1980 they founded an association and, on 16 October 1980, the Meeting-point first opened at Therwilerstrasse 7 in Basle, where it is still located today. Over the past 12 years, the beautiful town house has become a second home for many people. For the founders, the most important thing was to listen to the actual needs expressed by psychiatric patients, their concerns and what made them sad or angry. It took a great deal of work before people began to think and speak openly about their situation, and to gain the courage to believe that deplorable situations need not merely be accepted, but can be changed. Once an atmosphere of trust prevailed, the requests and needs of patients were conveyed to the relevant institutions and professionals.

Although professional people were involved in the original planning group, the founders were exclusively "lay people" — not professionals in the field of psychiatry. That is still the case today. The committee and the working team are made up of people affected, their relatives and voluntary co-workers. Decisions are taken democratically by all members at general assemblies held every two

A group of people came together to study ways of democratizing psychiatry

months, so everyone shares responsibility for the fate of the Meeting-point.

Women volunteers

Originally the financial resources consisted solely of members' contributions and donations, but since 1991 the group has been subsidized by the Federal Office of Social Insurance and the canton and the city of Basle. Although the team members can now be paid a small indemnity, part of the work is still performed on a voluntary basis. Almost all the team members active in the past 11 years have been women.

The *open meeting-point*, three times a week, is a place for interpersonal encounters and discussion, where people in the area of psychiatry can come out of their isolation and slowly regain a footing in the "outside world". The institution-free environment is very important, and becomes a circle of friends, where people laugh and cry and share their joys and sadness, but also where arguments take place and conflicts are resolved. Excursions and picnics are high points of the year, and three summer camps have been held.

A *conversation group* (an accompanied self-help group) meets once a week and focuses primarily on mutual help with day-to-day problems. This is a protected space, where trust makes many things possible.

The *guardianship group* is likewise an accompanied self-help group for people involved in a guardianship process who have trouble with their situation. This group clarifies their rights and obligations and encourages the first steps towards independence.

In the *health group* the focus is on health rather than disease. Meeting once a month, the group looks at alternative and fulfilling natural healing methods and seeks ways of living a more healthy life.

Work with relatives is an important part of group work. It is important for relatives to meet other people who have gone through the same, frequently painful, experience. The family is existentially affected by the illness of one of its members and needs help, just as patients do. Mutual help and understanding in self-help groups have proved their worth over many years. One crucial aspect for relatives is communication with specialists. This is a mutual learning process. Many professionals readily admit having learnt from relatives and their many years' experience.

A home, a sense of belonging...

Spreading the news

The group has been active in public relations. It publishes its own "Meeting-point News" with first-hand accounts, and presents its work in schools, in the press and on radio. It maintains contact with other psycho-social groups and institutions, and forms part of the Basle psychosocial network.

In the 12 years since the Democratic Psychiatry movement was founded, it has embarked on several innovative projects. These include the *Self-help Group on Work*, founded in 1983, which offers a protected work centre for people unable to hold down a regular job. A *crisis centre* was planned four years later to give people undergoing psychosocial crises the opportunity of receiving an intensive level of care for several days and nights (24 hours a day) without having to go into hospital. Unfortunately this project has been held up by lack of funding.

Enabling people to assume responsibility for themselves

The Therwilerstrasse Day Centre opened its doors in the autumn of 1990. The focus of this service is on management of everyday routine, stimulating people's pleasure in life through common activities. It also opens at weekends, a special feature that is particularly appreciated.

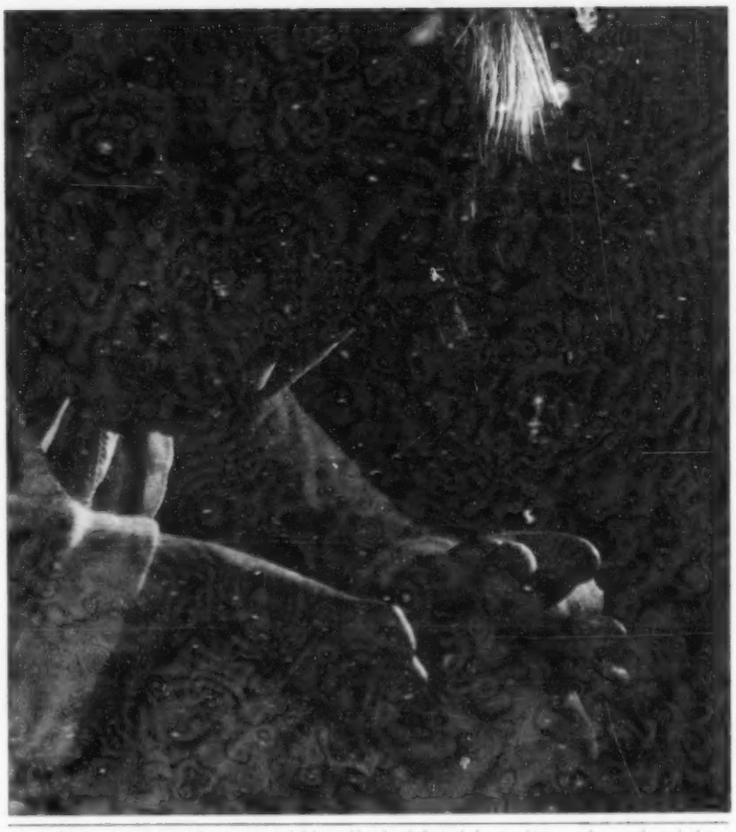
On the occasion of our tenth anniversary in October 1990, a woman friend of the movement said, "If the Meeting-point for Democratic Psychiatry did not exist, it would have to be invented." Most people who have faithfully attended our establishment over many years are of the same opinion. ■

Mrs Margot Wicki Schwarzschild is one of the founders of the Meeting-point for Democratic Psychiatry, Therwilerstrasse 7, CH-4054 Basle, Switzerland.

Profile of a health advocate

Judith Longstaff Mackay

Health advocates are crusaders for health — people with a strong sense of mission. World Health *invited Dr Mackay to describe how she became such a crusader; with some reluctance, she agreed!*



China has an urgent need to protect children, like this little girl, from taking up the smoking habit.

How does someone born on the north-east coast of England end up as a health advocate on tobacco control in China and Mongolia? This would have been an unlikely prediction before I graduated as a doctor in Scotland. But the process started after my intern year, when I moved to Hong Kong in 1967.

My first step towards health advocacy resulted from my work as a hospital physician being almost completely related to the end-results of smoking. There was a maxim on the male medical ward in Hong Kong that "we never admitted a nonsmoker." Dealing daily with incurable lung, heart and other smoking-related diseases made me realize that health would never improve unless prevention was given top priority.

The second influence was the women's movement, and especially its strong emphasis on self-help and preventive health. Women's health care has traditionally addressed gynaecological problems and paid less attention to the serious effects of smoking on women. It also became clear that women are being exploited and recruited by the tobacco companies through advertising images showing attractive, slim, successful women, combined with false messages of emancipation.

From the women's movement I learned about lobbying, initially for the abolition of the concubine law (whereby a man could legally have several wives although the reverse did not hold true), then for separate taxation, equal pay, maternity leave, and a refuge for battered women. Learning political and media lobbying (perhaps the best practical definition of an "advocate"), and learning to sense when to confront, when to cooperate, when to deal with issues quietly and when to go public, proved to be invaluable assets years later when I became a health advocate on tobacco issues.

Impelled by anger

I was precipitated into the tobacco scene when writing about smoking in the middle of a three-year health series published in a Hong Kong newspaper. The wrath of a transnational cigarette company descended upon me in a 1982 booklet, which concluded that the "anti-smoking lobby in Hong Kong is largely anonymous, unidentifiable, entirely unrepresentative and unaccountable." In contrast, the self-promotional booklet claimed, "the tobacco industry comprises identifiable, legal, accountable, commercial organizations."

This was a turning point, one of those single events that change one's life. This document, denying the health evidence ("it has not been proven that these illnesses are actually caused by smoking") and claiming to be an "important source of reliable information" on smoking, so enraged me that from that moment on I worked on tobacco control, abandoning curative hospital medicine in the process.

At first it was a lonely existence. Then support came from established tobacco control advocates (such as David Simpson, a member of the WHO Expert Advisory Panel on Tobacco or Health and then Director of Action on Smoking and Health (ASH) in the UK). In turn, I have been able to establish networks in Asia, so that there is now a sharing of information, experience and expertise between countries as diverse as Cambodia and Singapore.

A vulnerable target

While indigenous tobacco production and consumption remain major problems in Asian countries, it quickly became apparent that they are the focus of the powerful international tobacco cartel. With markets slowly decreasing in the West, these tobacco companies are now targeting developing countries, as indicated in an article entitled "Bright future predicted for Asia Pacific" in their own journal *World Tobacco*. Using such subheadings as "Growth potential" and "More smokers", the article estimated that sales in Asia alone would increase by at least 18% by the year 2000.

Not everyone views that prediction with such enthusiasm. Oxford epidemiologist Richard Peto predicts that in China alone, of all the children alive today 50 million will eventually be killed prematurely by smoking.

As if that wasn't bad enough, we are seeing the transnational companies adopting double standards towards Asia by, for instance:

- advertising in ways that have long been banned in their own countries;
- selling cigarettes without health warnings;
- challenging responsible government action on tobacco;
- threatening trade sanctions (from the USA) unless markets are opened to foreign cigarettes and advertising is allowed;
- targeting women, comparatively few of whom smoke at present;
- replacing simple, government monopolies with sophisticated commercial organizations.

A long road ahead

Asian governments are often preoccupied by other problems, such as high infant mortality or infectious diseases. These factors, combined with a relative absence of policy, laws or health education programmes, and with a lack of experience of dealing with tobacco cartel tactics, can leave these countries open and vulnerable to penetration by a foreign industry.

My job has involved speaking at conferences and testifying before government committees in exporting countries, asking that their tobacco companies adhere, at minimum, to the same standards in developing countries as in their country of origin, and that a product as uniquely harmful as tobacco should never be used in trade leverage.

The other side of my job has been to assist Asian governments to estimate the scope of their smoking epidemic, to establish their own national tobacco control programme, and in particular to advise in drafting tobacco control legislation.

The speed of action in some Asian countries and their long-term planning are both impressive. When I asked Vietnam's Minister of Health why his ministry was taking so many steps in tobacco control when his country had other, formidable health problems, he replied: "Of course, we are just thinking 30 years into the future." Only two years after the initial proposal, the Chinese government implemented a far-reaching tobacco law in January 1992, which when translated into action should save millions of lives. My job also takes me to remote areas, as with the current quit-smoking projects for rural and often illiterate Chinese farmers.

Many people ask whether the enormity of the problem of smoking in Asia is not daunting. The Chinese have an ancient saying: "It is better to light a candle than to curse the darkness."

Another Chinese saying, "A journey of 10 000 miles begins with a single step", drives home the fact that, while the first steps in reducing the tobacco epidemic have been taken in some developing countries, there is still a long road ahead. ■

No cigarette sales on World Health Day, says the poster. But much more needs to be done to prevent the millions of deaths from tobacco addiction.

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Strip cartoons for health

Philippe Videlier & Pierine Piras

Strip cartoons have frequently dealt with health-related subjects. Young people are particularly fond of strip cartoons and their heroes. Can they be used for educational purposes?

The strip cartoon was born in the 19th century by uniting pictures and text to tell stories in serial form. The strips animate scenes and dialogues, putting faces to names and painting a series of little scenes for the reader. Since the 1930s this type of narrative has had a strong influence on children; sales of illustrated magazines have steadily risen, even since the advent of television. Thus, the strip cartoon both reflects values in society and exerts a formative influence in recreational guise at a crucial stage of life: childhood and adolescence.

The social influence of strip cartoons is rarely discussed, since this medium is not seen as a legitimate part of school-based culture. And yet they are in a class of their own and even today, in spite of the ubiquitous small screen, they are a source of culture and education for very many young people. According to a recent survey in Europe, strip cartoon heroes are more popular among children than are sportsmen and sportswomen, scientists and pop stars. In France, for example, children favour Tintin, Asterix and Lucky Luke. From the USA to China and Japan, from Latin America to the Philippines and Zaire, the strip cartoon is a highly popular medium.

Strip cartoons have frequently dealt with matters of health, indeed it might be said that the two go well together. Adventure and humour are the stock-in-trade of cartoons, since they depend on surprise shifts of mood. From the outset, stories and pictures have used accidents, disease and disaster for laughs or for thrills. Almost a century ago, the cartoon artist Christophe put his *Savant Cosinus* in the hands of weird doctors who practised fake "new techniques" as they were imagined at that time. In our day the same method is used by Claire Bretécher with her satires on artificial insemination and test-tube babies, and by Schulz whose *Peanuts* offers ironic views of psychiatry that make us laugh but also make us think.

Victims and rescuers

Adventure stories, which have rapidly come to dominate strip cartoons (exotic stories, police adventures, science fiction and history) readily turn to the sphere of health. After all, where is the adventure if there is no danger or risk, which entails some relationship with health and therefore constitutes a health message? The heroes themselves and the characters they meet in their adventures are by turns victim and rescuer; in the desert they are exposed to sunstroke, in the jungle they are threatened by malaria and poisonous snakes, in sea stories they are threatened by scurvy, and in stories set in the Middle Ages the great plagues or leprosy decimate populations. At any moment characters can be hurt in an accident or a fight, which gives an opportunity for a health message, whether in word or in deed: thus Tintin, the classic hero, saves a child from drowning and gives him artificial respiration, in *The Blue Lotus*. Similarly, we watch Steve

Canyon, the American pilot created by Milton Caniff, fight a cholera epidemic in Africa; we applaud Mafalda, the perky, "with-it" Argentinian who puts her father off smoking with a simple remark, and we follow the adventures of the tragic Japanese hero Gen of Hiroshima who lived through the atomic nightmare.

Strip cartoons show many scenes illustrating health problems (as incidents in the story) and how to solve them (resolution of a crisis, a pre-condition for further progress). In the often rapid succession of events, we learn how to take a pulse, boil water to disinfect a wound, apply a tourniquet, make a splint or stretcher, and so forth. Ambulances, doctors, nurses, hospitals, dispensaries, and operating theatres make regular appearances.

A health problem or a social issue with a major bearing on health can even be the centre of the story. Two of Tintin's adventures, *Pharaoh's Cigars* and *The Blue Lotus*, are set against a backdrop of efforts to control the opium traffic in Egypt and in China. In a more modern vein, Charles Jarry's *Firebrands without Frontiers* deals with the traffic in human plasma in Brazil, which carries a risk of hepatitis B (AIDS was not a well-known issue when that episode was written). In a more recent album called *Mortal Sin*, a disease modelled on AIDS (with a retrovirus reminiscent of HIV) forms the setting of a solid science fiction adventure with plenty of drama.

Strip cartoons capture children's attention

The wind of change

Strip cartoons are strongly influenced by the cultural climate (the time and place) in which they are written. Consequently they reflect a society's behaviour and life-styles, healthy and otherwise: alcohol, tobacco, food and the environment loom large in strip cartoons which depict daily life as part and parcel of graphic narrative, where the message can be inferred only from close analysis of the context. One of the most striking changes is in the treatment of tobacco — from use of "harmless" cigarettes to an almost militant anti-smoking attitude on the part of the cartoon heroes.

Strip cartoons therefore reflect an image of society, one that is obviously simplified but need not be regarded as simplistic. Their main purpose is to entertain, but they have many other functions, one of which undoubtedly is to propagate the notion of health. The influence of strip cartoons seems to be accepted today, since health organizations use the famous heroes of comic strips to put across their messages (the ex-smoking cowboy Lucky Luke against tobacco, Superman for keeping the environment clean, and so on), as well as specially written educational stories, as UNICEF has done in Nepal or the AIDS control programme in Peru.

Even though strip cartoons are often erroneously disregarded as part of the culture in many countries, their importance should not be ignored. The messages they impart, neither dangerous nor beneficial in themselves, can contribute to the education of young people — and adults too — provided the story is a good one. ■

Dr Philippe Videlier is Historian and Research Worker at the National Centre of Scientific Research (CNRS), Lyon, and Pierine Piras is a Librarian with the Library of the City of Lyon. Their address is: Maison Rhône-Alpes des Sciences de l'Homme, 14 Avenue Berthelot, 69363 Lyon Cedex 07, France. They are the authors of a study for WHO of health messages in strip cartoons, to be published by Presses du CNRS/Editions Frison-Roche, France.

A life — that's really worth something!

The team in Rennes working on their video film

We wanted to show that we are capable of doing positive things, like starting up a project and carrying it through.

Being young isn't always easy! All manner of difficulties at school, at home with the family and in personal life tend to build up until you are tempted to pack it all in and join those others — usually semi-literate — who live on the margin of society. A growing number of adolescents are doing just that in many cities of the industrialized world.

What can young people do to come to terms with themselves, to recognize the value of education — and to take an informed interest in health? After all, health is not just a matter of physical well-being; it concerns learning to live at ease in the family and in the social and cultural setting, but also feeling comfortable within our own body, with all its reflexes, yearnings and desires — facing the whole world all on your own.

Young people need to be helped to find again or to acquire that basic self-awareness that is essential if the whole being is to flourish as it should. It was with this in mind that, in November 1990, a group of health professionals and youth leaders working with the Healthy Cities movement in Rennes, in western France, arranged a week-long discussion forum for adolescents on the theme: What does health mean? The week culminated in a session where the young people were encouraged to express their views very freely.

Documentary videos, a photo exhibition, a fashion parade, a description of life in a boarding school, sequences showing how a photo novel is made, but also sports such as skateboarding — all these were means of persuading young

people to say what they really feel and to share their feelings with other young people or with those adults who accepted their invitation.

But the youngsters didn't stop there. Thanks to a workshop which they created shortly after the discussion week, they were able to produce a booklet about "their" forum.

"Doing positive things"

One year later, they made a video film on the theme of health as seen in their own lives; this film was shot at a suburban house in Rennes and presents some of their real-life situations. For instance, it shows how a very young adolescent called Jonathan, without having meant to, gets involved in a break-in.

They agreed to talk to *World Health* about this experiment, about their worries, their aspirations, their concept of health. Here are some extracts, in their own words, of what they said.

- Me, I am really anxious about the future! Will I get a job, will I succeed in life, will I find a girlfriend, will I get involved in juvenile crime?
- What we wanted to say in this experiment was that there are a lot of negative things which lie in wait for young people, and yet there are ways of getting around such problems or taking the heat out of them.
- What we have done is to show how our suburb operates. It's a negative picture, but we also wanted to show that young people have their good side — that we are capable of doing positive things, like starting up a project and carrying it through.
- Young people are not totally negative or totally positive — there are always two aspects to our way of life.
- We wanted to show this situation — problems of juvenile crime — and to suggest some positive actions before things get even worse.
- Some youngsters who have seen our film have laughed at us; they haven't tried to understand what we were trying to say. It isn't all that easy to make a good film — you try and the others tease you; it makes you want to give up. But they are just choked up because they didn't have the guts to make a little film like that, something that a lot of people are going to see. That's what really matters to us.
- AIDS — it's really stupid if young people get mixed up in that! They've got to be sensible, aware and clear-headed, so that they know the right ways and the wrong ways. But from the start, somebody has to tell them what's what.
- AIDS is a truly serious problem, but everyone's been warned; they have to use a condom if they want to be protected — it's up to them to choose. Considering how many cases of AIDS there are, I think people don't take enough precautions; parents have to talk to their kids to tell them what's right and what's wrong. When young people do stupid things they've usually been tricked into it by someone else.
- Alcoholism and drugs — I suppose some people get addicted. There's a cure for it you know! But not with medicines. There have to be people around to back you up, help you, give you the right sort of environment.
- Diseases, drugs, getting old — it really gets you down! Cancer, AIDS — they are frightening too. Something has to be done about it. If everybody made the right effort, perhaps the situation would change. But health — well, everything depends on money. You see it all on the television: looking after a drug addict costs the state a lot; health ought to be free. After all, it's a matter of saving a life. And a life — that's really worth something! ■

This article resulted from an interview with young people who took part in a discussion forum in the context of the Healthy Cities movement of Rennes. The address is Hôtel de Ville, B. P. 26A, 35031 Rennes Cedex, France.

Young Cambodian refugees: how can they be helped to have meaningful lives?

The key to child survival

Adelpha S. Mabulay & Vida Subingsubing

Named after the local word for the youngest child in the family, BUNSO is a national coalition promoting and protecting the health and rights of mothers and children.

Breast-feeding: key to child survival

Ten years ago, a dairy company dumped on the markets of the Philippines the time-expired and vitamin-deficient milk base of an infant formula drink. When this became known, it sent consumers protesting on the streets and in parliament. While the movement failed to stop the company from selling more of this product, it succeeded in raising consumer awareness. This later found expression in organizations and community actions which vigilantly kept watch over consumers' health rights, particularly those pertaining to mothers and children.

From these beginnings, a multisectoral coalition of community-based groups was born in 1981 to pursue the protection of infants' health. The group was named BUNSO, the Pilipino vernacular for the youngest child in the family. BUNSO was committed to promoting maternal and child health, with emphasis on breast-feeding as the superior mode of infant feeding.

Infant mortality in the Philippines stood at 51.5 per 1000 live births in 1989. This meant that for every 1000 live births, 52 would die before they reached the age of one year. Two-thirds of these deaths would be due to infectious diseases — with pneumonia and diarrhoeal diseases topping the list — and malnutrition.

Breast is best

This situation was aggravated by the decline in breast-feeding rates which fell from 87% in 1973 to 80% in 1984. Despite the scientific recognition that breast-milk provides the ideal nourishment for infants, a BUNSO study of infant feeding practices in several government hospitals revealed that breast-feeding was practised by a mere 41% of the mothers sampled. Breast-feeding was lowest among women in urban areas.

Conscious of this alarming trend, BUNSO initiated various activities aimed at reviving the popularity of breast-feeding, a practice so essential to child survival and yet so gravely threatened with extinction. BUNSO's membership was drawn from such community-based groups as consumers, the church, health workers, women, and the urban poor, and this ensured widespread participation.

Through the joint efforts of these groups, BUNSO struggled to get approval for the Philippine Milk Code, which seeks to regulate the marketing and distribution of breast-milk substitutes, supplements and related products. Designed by BUNSO, other nongovernmental

organizations and the Department of Health in 1983, the Code finally became operational in 1986.

Now that the Code is in place, its sponsors are currently monitoring the marketing and advertising practices of dairy companies to ensure that its provisions are not violated. Milk Code advocacy is actively being pursued to make more consumers aware and assertive of their rights.

Community participation in this field is not limited to Code monitoring and advocacy. In 1984, BUNSO conducted breast-feeding seminars for pregnant and lactating mothers in 11 poor urban areas in Metropolitan Manila. Some 1000 mothers underwent training on the advantages of breast-feeding, the disadvantages of bottle feeding, and correct breast-feeding techniques.

In time, mothers were not only breast-feeding their infants but were also actively advocating breast-feeding within and outside their communities. Mothers figured prominently in BUNSO-sponsored motorcades calling for stricter implementation of the Code. Eventually, they received training to help them in planning and running their own community programmes.

Immunization against childhood diseases is a basic human right.

Mothers' best friend

The success of BUNSO's community work led to the development of Breast-feeding Mothers' Counsellors. Each counsellor is trained to provide guidance and support to pregnant and lactating mothers: she invites mothers to a breast-feeding class, and later makes house visits to advise them if they are having problems with breast-feeding or simply to make sure they get all the support they need.

The counsellors, together with the mothers, represent a defence line to counter misleading information which might discourage pregnant and lactating mothers from breast-feeding. This system also encourages mother-to-mother counselling and support.

In 1989, a lactation centre was set up in East Avenue Medical Centre, where Breast-feeding Mothers' Counsellors were able to aid women who gave birth in this Quezon City government hospital. Subsequently, facilities offering a similar package of services were set up in health centres near the community.

BUNSO's breast-feeding programme continues to explore and expand into new spheres in order to make its activities more responsive to the needs of mother and child. It works in cooperation with the maternal and child health and nutrition programmes of BUNSO, distinct but part of the same mother and child concern.

This year, BUNSO has targeted the setting up of support systems in communities and factories to make breast-feeding easier, especially for working mothers. It is also studying the possibility of income-generating projects to augment the community's income.

The guiding principle of BUNSO's work is to support mothers' groups by getting them interested in counselling mothers, managing infant health care services, and starting livelihood projects. Through these, it is hoped that the community may regain self-reliance and self-esteem. Only through building community awareness about proper child health and nutrition, by equipping people with proper skills, and by actively engaging the community can BUNSO's objectives be achieved. ■

Ms Adelpha S. Mabulay is Secretary General of BUNSO and Ms Vida Subingsubing is the Resource Centre Coordinator. BUNSO's address is 5 Basilan Street, Philamlife Homes, Quezon City, Philippines.

Ideas for action

Learning about your community

Women's groups, scouts, health volunteers, local organizations and health teams, should know their community if they are to be effective in improving its health. You may already know many things about your community, especially if it is a small one. But do you know *enough* about it? You will learn more by talking in a systematic way with its leaders and other people. Do not ask too many questions though; it is better to *observe*, *listen* and *learn!* Here are some of the things you should find out.

- How many people are there in the community, and how many of them are young, middle-aged, and old?
- How do people get food? How do they earn money? Are they farm workers, fishermen, cattle-farmers, estate workers, factory workers? How do they spend their free time? Do they work at night?
- Do children work? How many of the children attend school?
- Is the community poor? Is it becoming poorer or less poor? Is its standard of living higher or lower than the average for the country? Are there good markets, good roads? Is there a clean water supply? Is there electricity, a telephone service, a bus service?
- How do families live? What are the houses like? Do they have a system of sanitation? Are the houses clean and free of pests?
- Who makes decisions within the family? How many children are there in the average family? How are the children fed and how are they taught? What are the most common beliefs, values and traditions?
- What are the main health problems and what are their causes? Some causes of bad health are:
  - too many people living close together;
  - not enough water or the water is not safe;
  - not enough food of the right kind;
  - unclean houses in dirty surroundings;
  - no way to keep cool in the heat or to keep warm in the cold;
  - no latrines or the latrines are dirty;
  - no protection against insects that carry diseases;
  - the health centre is difficult to reach;
  - people cannot read and thus do not learn about health and healthy habits.

Talk to various groups and people: families or households (both rich and poor), those who make decisions for the community about the community and members of special groups. Try to find out:

- what part of their income do they spend on health?
- what community problems are

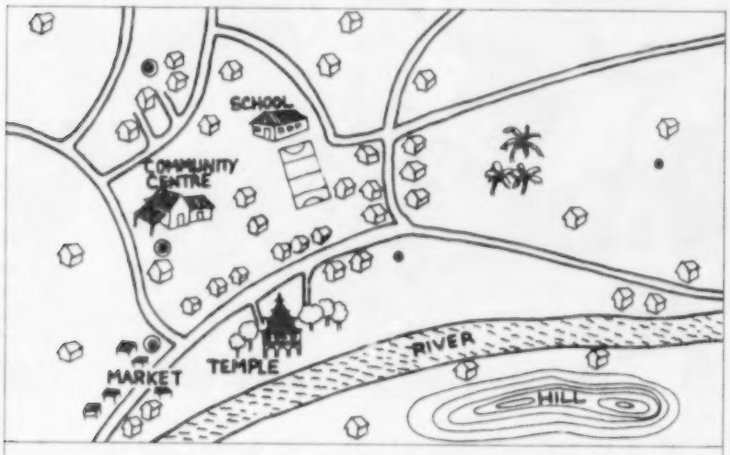
Enough water, safe water: a must for good health.

they especially concerned about?
- what have they been doing about these problems?
- what do they think can be done?
- who are the leaders, or those who make the decisions for the community? They may be tribal leaders, religious leaders or political leaders. They are the ones who are most likely to help in improving health. Other people whose opinions and support are valued may include the elders, landowners, money-lenders or businessmen.

Find out how the community is organized and who runs its affairs.

For example:
- Which group makes decisions for all the people? Is it a development committee, a political body, or some other group?
- Does this group deal with all the affairs of the community? Or does it have subcommittees that look after different needs of the community, such as health, water supply and education?
- Is there a health committee? Who are its members and how are they chosen? What are their tasks? How often do they meet? Are all sections or groups in the community represented?
- What other groups are there? For example, a women's group or a farmers' cooperative.

If you are a schoolteacher, why not ask your students to do a community survey based on questions like these? Then you could call a meeting of parents and ask the students to present their findings. Maybe a movement to improve health could be started?



Draw a map of the area...

Drawing a map of your area

A map is a useful tool to study the health and sanitary situation in a community. If there is not already a good map of your area, ask other people (for example, the schoolteacher and schoolchildren) to help you to draw one. This map will show the rivers, schools, health centres, temples, roads, shops and other important places. Take the map to the community committee and place it where the people can see it.

As new information comes in, mark it on the map. For example, show the wells or houses that are not in good condition. Keep the map up-to-date. It will make it easier to detect some of the health problems, and also to show by how much community health improves from year to year. ■

Assessing the needs of your community

The above is adapted from ***On being in charge — A guide to management in primary health care****. WHO, Geneva, 1992, price Sw.fr.30 [developing countries Sw.fr.21], and* ***The community health worker****. WHO, Geneva, 1987, price Sw.fr. 22 [developing countries Sw.fr.15.40].*

WHO in action

Safe and sound

Four evenings a week, as the sun sinks behind the peaks of Lesotho, a soft hissing can be heard within the shadows of St Gabriel's Mission health centre at Quatchers Neck. In the last light, Nurse Virginia checks her records and listens attentively for the bell which will mark the end of the steam sterilization cycle. The portable steam sterilizer, perched like a singing kettle on a small gas heater, has transformed her working life. At dawn the next day, she will carry this vital equipment, packed in the same blue shoulder bag that contains all the sterile instruments needed for the day, high into the mountains to conduct an immunization and antenatal clinic for these remote communities.

Gone are the days when frustrated mothers waited for one or two shared syringes to be boiled for a few minutes between each injection. Gone, too, are the days when contaminated needles introduced new infections.

Virginia's portable steam sterilizer is one of half a million sterilizers introduced worldwide, since 1984, by WHO and UNICEF, following very positive experiences in Brazil where similar small steam sterilizers had been used. The sterilizers guarantee complete sterility, even when carried or stored for long periods after the heating cycle. ■

Gone are the days of unsafe injections

Perfect pictures

People in Parakou-boko, Benin, are lucky. Their local hospital has a dream of a machine — the WHO Basic Radiological System (BRS) X-ray unit. Sleek and smart, versatile yet rugged, this single ingenious machine can be used to X-ray infants or the elderly, to examine a broken limb or severe head injury, to look for the cause of a lingering cough or a pain in the stomach — or elsewhere.

Using the WHO-inspired machine, doctors at the centre will be able to find out what is wrong with the patients and how they should be treated. They know they will be getting the best quality pictures in the world. Independent tests have shown that image quality using the BRS excels that produced by conventional equipment costing several times as much. Which is why — even in rural Parakou-boko — the local hospital can afford to give its patients the very best.

This machine, developed to meet Third-World needs, is so very good, in fact, that units can now be found in the hospitals of the world's wealthiest nations. ■

The WHO-inspired X-ray machines can diagnose many ills

WHO on . . .

Travel sickness

In the age of jet travel, international travellers are subjected to various forms of stress that may reduce their resistance to disease: crowding, long hours of waiting, disruption of eating habits, and changes in climate and time zone. These factors may in themselves provoke nausea, indigestion, extreme fatigue and insomnia.

The crossing of several time zones disrupts the sleeping and waking cycle, producing jet-lag. The time needed for complete readjustment depends on the number of zones crossed and may be a week or longer. It is advisable to schedule some periods of rest in the first few days after arrival. It may also be useful to take a short-acting sleeping pill for the first few nights after the journey. People who have to take medication according to a strict time schedule (e.g., insulin, contraceptive pill) should seek a doctor's advice.

Travel sickness is very rare in the case of air travel. However, people travelling by sea who have no experience of sea travel would be wise to take supplies of an anti-seasickness drug. Travel-sickness drugs and other medicines that need to be taken regularly should be carried with the hand baggage. ■

From: International Travel and Health, World Health Organization, Geneva, 1992. (Price Sw.fr.14. Price for developing countries: Sw.fr. 9.80).

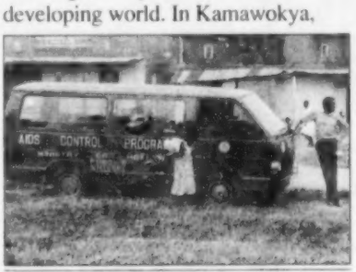
World AIDS Day 1992

World AIDS Day is observed every year on 1 December. In 1992 it will focus on the crucial role communities can and must play in the fight against AIDS. The theme of the day will be "AIDS: A community commitment."

In 1991 the theme of "Sharing the Challenge" triggered concerts, parades, seminars, lectures, exhibitions and media events which celebrated, cemented and confirmed partnerships of all kinds in the fight against AIDS around the world.

Dr Hiroshi Nakajima, Director-General of WHO, says "The community — be it the neighbourhood, the school or college community, a professional group or the smaller support network composed of family or friends — is a uniquely powerful force in societies everywhere which needs to be harnessed if we are to bring the AIDS pandemic under control".

This year's theme is inspired by the countless examples of communities rising to the AIDS challenge, many of them in the developing world. In Kamawokya, near Kampala in Uganda, a small community of churchgoers has been acting as the link between people with AIDS and the local Nsyamba Hospital. The community makes sure that patients are taken to the hospital, leads mobile medical teams to those who are too sick to travel, and helps them wash and bathe. It also collects money to feed the poorer patients. Their unfailing devotion has helped doctors at Nsyamba reach 3 – 4 times as many AIDS patients as they could have without such committed community support.



The mobile teams of Uganda go out to find AIDS patients.

Communities are crucial not only for care and support but also for prevention. While individuals can be educated and motivated to change their sexual behaviour, experience shows that this process is greatly aided if individual life-style change is backed up by a community commitment to safer sex and other protective values.

For further information regarding World AIDS Day, please contact Catherine Dasen, Global Programme on AIDS, WHO, 1211 Geneva 27, Switzerland. Tel. (4122) 7914765/ 7914674. ■

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In the next issue

Water is essential, not only to health, but to life itself. On our increasingly overcrowded and polluted planet, clean water is becoming a scarce resource and must be protected. The July–August issue of *World Health* will describe the situation and some of the action being taken to improve it. ■

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